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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION OFFICE
PHYSICIAN'S / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

FILED
STATE FILE NUMBER 2018-008985

BULGER, James J.
NAME OF DECEDENT

**FUNERAL DIRECTOR**

| 1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last) | 2. SEX | 3. SOCIAL SECURITY NUMBER |
|---|---|---|
| James Joseph Bulger Jr. | Male | |

| 4a. AGE (Last Birthday) (Years) | 4b. IF UNDER 1 YEAR Months / Days | 4c. IF UNDER 1 DAY Hours / Minutes | 5. DATE OF BIRTH (MM/DD/YYYY) | 6. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|
| 89 | | | 09/03/1929 | Boston, MA |

| 7a. RESIDENCE (STATE) | 7b. COUNTY | 7c. CITY OR TOWN | 7d. STREET AND NUMBER | 7e. APT. NO. | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS? |
|---|---|---|---|---|---|---|
| MA | Suffolk | Boston | 17 Twomey Court | | 02127 | ☐ Yes ☒ No |

7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT. — STREET & NUMBER | APT. NO. | CITY OR TOWN | COUNTY | STATE | ZIP

| 8. EVER IN US ARMED FORCES? | 9. MARITAL STATUS AT TIME OF DEATH | 10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.) |
|---|---|---|
| ☒ Yes ☐ No | ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown | |

| 11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) | 12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) |
|---|---|
| James Joseph Bulger Sr. | Jane V. McCarty |

| 13a. INFORMANT'S NAME | 13b. RELATIONSHIP TO DECEDENT | 13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) |
|---|---|---|
| John P. Bulger | Brother | 17 Twomey Ct Boston, MA 02127 |

14. PLACE OF DEATH (Check only one: see instructions)

IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☒ Other (Specify): Prison

| 15. FACILITY NAME (If not institution, give street & number) | 16. CITY OR TOWN, STATE, AND ZIP CODE | 17. COUNTY OF DEATH |
|---|---|---|
| U.S. Penitentiary Hazelton | Bruceton Mills, WV 26525 | Preston |

| 18. METHOD OF DISPOSITION | 19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place - location in Box 20.) |
|---|---|
| ☐ Burial ☐ Cremation ☐ Entombment ☐ Donation ☒ Removal from State ☐ Other (Specify): | Saint Josephs Cemetery |

| 20. DISPOSITION LOCATION (City, State) | 21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY |
|---|---|
| Boston, MA | Charleston Mortuary Service 1101 Bigley Avenue Charleston, WV 25302 |

| 22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH | 23. LICENSE NUMBER (Of Licensee) |
|---|---|
| ▶ Dale R. Burger — Dale R. Burger | |

**LICENSED HEALTH PROFESSIONAL OR CORONER**

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

| 24. DATE PRONOUNCED DEAD (MM/DD/YYYY) | 25. TIME PRONOUNCED DEAD |
|---|---|
| 10/30/2018 | 0904 |

26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.) ▶

27. DATE SIGNED (MM/DD/YYYY)

DATE/ TIME OF DEATH MUST BE COMPLETED →

TYPE/PRINT IN PERMANENT BLACK INK

**PHYSICIAN, QUALIFIED APRN, OR NON-PHYSICIAN CORONER**

| 28. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) | 29. ACTUAL OR PRESUMED TIME OF DEATH | 30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? | IF YES, MEDICAL EXAMINER CASE # |
|---|---|---|---|
| found 10/30/2018 | found 0821 | ☐ No ☒ Yes | 18-6303 |

CAUSE OF DEATH

31. PART I. Enter the chain of events – diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. Add additional lines if necessary.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Blunt Force Injuries of the Head | minutes |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I.

| 32a. WAS AN AUTOPSY PERFORMED? | 32b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? |
|---|---|
| ☒ Yes ☐ No | ☒ Yes ☐ No |

| 33. DID TOBACCO USE CONTRIBUTE TO DEATH? | 34. IF FEMALE | 35a. CAUSE/MANNER PENDING? | 35b. FINAL MANNER OF DEATH: |
|---|---|---|---|
| ☐ Yes ☐ Probably ☒ No ☐ Unknown | ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the last year — N/A | ☐ Pending Investigation ☐ Date Amended See 35b. for Final Manner of Death | ☐ Natural ☐ Accident ☐ Suicide ☒ Homicide ☐ Could not be determined |

**MEDICAL EXAMINER OR CORONER ONLY**

| 36a. DATE OF INJURY (MM/DD/YYYY) | 36b. TIME OF INJURY | 36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area) | 36d. INJURY AT WORK? |
|---|---|---|---|
| found 10/30/2018 | found 0821 | Prison Cell - U.S.P. Hazelton | ☐ Yes ☒ No |

36e. LOCATION OF INJURY: 1610 Skyline Drive; Bruceton Mills, WV 26525
Street & Number: | Apt No.: | City or Town: | State or Country: | Zip Code:

| 36f. DESCRIBE HOW INJURY OCCURRED | 36g. IF TRANSPORTATION INJURY: ROLE: | SEATBELT RESTRAINT STATUS: |
|---|---|---|
| Assaulted by other(s) | ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) | ☐ Restrained ☐ No restraint ☐ Unknown HELMET STATUS: ☐ Helmet ☐ No helmet ☐ Unknown |

**PHYSICIAN, QUALIFIED APRN, OR CORONER ONLY**

37a. CERTIFIER (Check only one):
☐ Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☒ Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

Signature of Certifier ▶ [signature] Date Certified 10/31/18

| 37b. PRINT NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31.) | 37c. TITLE OF CERTIFIER |
|---|---|
| Allen Mock, CME, OCME Main Charleston, WV | MD |

**STATE/COUNTY ORIGINAL**

FORM VS-002 (Rev. 9/2017)

**OFFICE USE ONLY**

| 38. FOR OFFICIAL REGISTRAR USE ONLY- SIGNATURE OF REGISTRAR | 39. FOR OFFICIAL REGISTRAR USE ONLY- DATE FILED |
|---|---|
| ▶ [signature] Gary L. Thompson | 11/14/2018 |